The POLICY Project

Reproductive Health
Case Study

JAMAICA

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in collaboration with

Research Triangle Institute (RTI)

The Centre for Development and Population Activities (CEDPA)

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Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations in the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country reports is to describe the policy environment for reproductive health and the role played by the 1994 ICPD in sparking and shaping policies and programs in reproductive health.

The field work for the Jamaica Reproductive Case Study was conducted from December 1 to 12, 1997. Thirty-five persons who are active in the population sector were interviewed. Respondents were based in Kingston, Ocho Rios, and Mandeville, and included representatives from government organizations, nongovernmental organizations, U.S. technical assistance organizations, research organizations, donors, the private sector, and service providers.

Jamaica has adopted the definition of reproductive health from the ICPD *Programme of Action*, although the country has not yet written a reproductive health policy. Instead, the 1995–2015 *National Plan of Action on Population and Development*, which was designed to implement the (revised) 1995 *National Population Policy*, makes note of reproductive health. The structures and processes of health policymaking in Jamaica generally rest with the government, with participation from individuals and organizations outside of government. While the Population Policy Coordinating Committee has discussed development of a reproductive health policy, the committee suggested that the National Family Planning Board (NFPB) and the Ministry of Health (MOH), through the Family Planning Coordinating Committee, submit a proposal for the policy. One obstacle to developing a policy is that no one has time to draft it. There is strong support for the components of reproductive health in Jamaica, yet few people are aware of the definition of reproductive health as an integrated package of services.

Jamaica has strong public sector family planning, maternal and child health (MCH), and STD/HIV/AIDS services. It also benefits from a well-developed network of private providers of health care services. In the public sector, family planning and MCH services are integrated to some extent, and the MOH is discussing the integration of STD/HIV/AIDS services into family planning/MCH services. Nonetheless, institutional "turf" issues hamper the full integration of services. Currently, adolescents—the group that is Jamaica's chief priority for reproductive health care—and men account for the main gaps in coverage.

Jamaica faces several challenges as it develops a reproductive health policy and integrated program. It needs a consensus definition of reproductive health and a policy to guide program development. At the program level, the MOH and the NFPB could set priorities for reproductive health interventions and develop operational plans for expanding services. Human resources are a constraint in Jamaica, particularly in the public sector. The MOH needs additional staff, and all staff members require special training in reproductive health. Stakeholders in Jamaica need to work together to plan innovative projects to provide reproductive health care to adolescents and men. In addition, the NFPB and the MOH must clearly define their respective roles in implementing reproductive health activities. Finally, as donor funds are reduced in Jamaica, the government will have to make an increasing financial commitment to providing reproductive health services to Jamaicans.

Abbreviations

AIDS	acquired immune deficiency syndrome
AWOJA	Association of Women's Organizations in Jamaica
CARICOM	Caribbean Community
CHA	community health aide
CPS	Contraceptive Prevalence Survey
EPI	Epidemiology Unit of the Ministry of Health
FAMPLAN	Family Planning Association of Jamaica
FHI	Family Health International
FLE	family life education
FMU	Fertility Management Unit
FPCC	Family Planning Coordinating Committee
HIV	human immuno-deficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IUD	intrauterine device
JRHS	Jamaica Reproductive Health Survey
MAJ	Medical Association of Jamaica
MCH	maternal and child health
MOH	Ministry of Health
NAC	National AIDS Committee
NFPB	National Family Planning Board
NGO	nongovernmental organization
PAC	Parish Advisory Committee
PHC	primary health care
PIOJ	Planning Institute of Jamaica
PPCC	Population Policy Coordinating Committee
SDP	service delivery point
STD	sexually transmitted disease
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U. S. Agency for International Development
UWI	University of the West Indies
WHO	World Health Organization
WROC	Women's Resource Outreach Centre

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified the worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on their epidemiological significance and recommendations from the ICPD *Programme of Action*, reproductive health care in these case studies is defined as including the following key elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services** and safe abortion services where permitted by law;
- prevention and treatment of reproductive tract infections (**RTIs**) and sexually transmitted diseases (**STDs**) and **HIV/AIDS**;
- provision of **reproductive services to adolescents**;
- improvement of **maternal and infant nutrition**, including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers,** including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with key individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, NGOs, women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support of and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

The field work in Jamaica was conducted from December 1 to 12, 1997, and 35 persons were interviewed. Respondents were based in Kingston, Ocho Rios, and Mandeville. Appendix 1 lists the organizational affiliations of respondents.

2. Background

Jamaica is a Caribbean island inhabited by about 2.5 million people. With an annual rate of population growth of 1.0 in 1996, one-half the population lives in the island's rural areas (PIOJ, 1997). The total fertility rate fell from 5.3 in 1970 to 2.8 in 1997 (McFarlane et al., 1998). Migration has been a major component of population change in Jamaica since the 1970s; patterns over the past decade, however, indicate that out-migration may be slowing. The per capita gross national product was $1,510 in 1995. While 45 percent of the labor force in 1995 were women (World Bank, 1997), many women are employed in marginal occupations—domestic service, informal trading, field laborers—and earn little more than subsistence wages. Many, therefore, see their material welfare as dependent on access to men's wages, and childbearing as essential to continued support. Children are believed to help cement relationships, and thus fertility is highly valued (Bailey et al., 1988).

In the social context of reproduction in Jamaica, sexual intercourse, particularly among the poor, begins at an early age with a series of "visiting" relationships. These relationships usually give way to common law unions and, perhaps ultimately, to legal marriages. According to the 1997 Jamaica Reproductive Health Survey (JRHS), of those women aged 15 to 45 in union, 24 percent were married, 35 percent were in a common law union, and 42 percent had a visiting partner. Parenting with multiple partners is common. In the 1997 Contraceptive Prevalence Survey (CPS), 51 percent of women age 15 to 19 reported sexual experience; by age 20 to 24, fully 90 percent of women had sexual experience. Contraceptive prevalence in Jamaica has increased in the past two decades from 38 percent in 1975 to 64 percent in 1997. The 1997 JRHS noted that 60 percent of births were either unwanted or mistimed (McFarlane et al., 1998).

Jamaican women and men use contraceptives within a health environment that is different from that of many other places. Jamaica—and the Caribbean—are known as areas with high rates of hypertension, diabetes mellitus, and cervical cancer, all conditions of concern in contraceptive use (PAHO, 1990; Grell, 1987; Morrison, 1983; Allyne et al., 1991; Poddar et al., 1986). The leading causes of hospitalization among Jamaican women include complications of pregnancy, cardiovascular diseases, diseases of the genito-urinary system, breast and cervical cancer, diabetes mellitus, and perinatal conditions (McCaw-Binns, 1993). According to the 1997 JRHS, 51 percent of women had ever had a Pap smear and 15 percent of women said they had had a Pap smear in the last year. In 1997, 59 percent of women said they received prenatal care during their last pregnancy (McFarlane et al., 1998). In 1990, health care staff attended 88 percent of births. The maternal mortality ratio in 1995 was 120 per 100,000 women (World Bank, 1997).

Jamaica recorded its first AIDS case in 1982; by the end of December 1996, 2,060 cases had been reported, of which 62 percent were male. Pediatric AIDS accounted for 7.5 percent of all AIDS cases. HIV prevalence in high-risk areas was estimated at 24.6 percent in 1995 and in low-prevalence areas at 0.7 percent (Bureau of the Census, 1997). STD rates in Jamaica are high. A recent study of female family planning clients in two clinics in Kingston found that 27 percent of clients had at least one STD (Behets et al., 1997).

Adolescent pregnancy presents a serious social and health problem in Jamaica (McNeil et al., 1983; Barnett et al., 1996; NFPB, n.d.). Jamaica's adolescent pregnancy rate, 108 births per 1,000 women age 15 to 19, is among the highest in the Caribbean. According to the 1993 CPS, fully 40 percent of Jamaican women have been pregnant at least once by age 19; one-quarter of births in Jamaica are to teenage mothers.

Among women age 15 to 19 who gave birth to a child in the last five years, only 15 percent planned their pregnancies. Almost one-third of ever-pregnant women age 15 to 24 became pregnant while still in school, and only 15.6 percent returned to school after the birth of their child (Morris et al., 1995). Adolescent pregnancy in Jamaica is directly related to early initiation of sexual activity and nonuse of family planning. In 1997, the average age at first intercourse was 15.9 among women and 13.4 among men. Among young adults age 18 to 24 in 1997, 56 percent of women and 31 percent of men used family planning during their first sexual experience (McFarlane et al., 1998).

3. Policy Formulation

Although under the official purview of the government, policymaking for reproductive health is a collaborative approach between the government and NGOs.

A. Structures for Policymaking

National Level

> "If you want to make legal and policy changes, you have to go through a government agency. They are the ones who can bring it to a minister who takes it to Parliament."
>
> Donor representative

The structures and processes of health policymaking in Jamaica generally rest with the government, although individuals and organizations outside the government have opportunities to participate. Three government agencies share responsibility for policymaking in the area of family planning and reproductive health: the Planning Institute of Jamaica (PIOJ), the National Family Planning Board (NFPB), and the Ministry of Health (MOH). Line ministries are expected to implement the policies.

The PIOJ sends policies to the cabinet through the Minister of Planning and Finance. It is the secretariat for the Population Policy Coordinating Committee (discussed in more detail below) and in that capacity took the lead in revising the population policy in 1995 and developing the Population and Development Strategy the same year. The PIOJ also provides the government with population projections to ensure transparency in decision making.

The NFPB was created as a statutory board under the MOH in 1970. Its role then was to prepare, carry out, and promote sustainable family planning services in Jamaica. In the mid-1970s, the MOH assumed responsibility for family planning service delivery as part of its broader health care program. At the same time, the NFPB's role shifted to administering the technical program in the field of family planning. NFPB activities included setting policy direction, managing and distributing contraceptive supplies (provided through international funding), promoting family planning both within and outside the public sector, developing and disseminating education and other material related to family planning, and training nongovernmental staff in family life education.

In addition to family planning services, the MOH also provides STD/HIV and other reproductive health services throughout Jamaica. Because of the MOH's responsibility for implementing services, ministry representatives are highly influential members of policy and coordination committees.

Other government agencies are directly involved in advising on policymaking on topics related to reproductive health, including the Bureau of Women's Affairs (through the Ministry of Labor and Social Welfare) and the Ministry of Education, among others. These ministries operate programs that address issues such as reproductive rights, violence against women, and youth programs, including family life education.

Various committees advise the government on specific components of reproductive health, most notably the Population Policy Coordinating Committee (PPCC) and the National AIDS Committee (NAC). The PPCC—established in 1982—meets quarterly and is made up of representatives from government agencies. The director of PIOJ chairs the PPCC and its vice chair is the director of the NFPB. The PPCC is responsible for coordinating, monitoring, and developing population policies. PIOJ would like the PPCC to become the Population and Development Committee and thereby reflect the link between population and economic development activities. PIOJ envisions that the Population and Development Committee would include parliamentarians to ensure better coordination with the National Planning Council (of which there is a sustainable development subset), the Economic Council, and the Human Resources Council, among others. If including parliamentarians is not possible, PIOJ may recommend that the entire cabinet deal periodically with population and development issues.

The NAC, established in 1988, has a membership of 60 representatives from the public sector, the private sector, and NGOs. Its subcommittees are responsible for advocacy, fundraising, community mobilization, legal and ethical issues, education, and care/counseling.

The Family Planning Coordinating Committee (FPCC), established several years ago in response to USAID project activities, is made up of the NFPB and the MOH. Until recently, it included only the MCH Unit of the Primary Health Care Division of the MOH, but the Epidemiology Unit (which runs the National AIDS Program) is now also a member. The FPCC would like to change its name to the Reproductive Health Coordinating Committee (RHCC) and change its terms of reference accordingly.

> "In meetings, the government gets recommendations for policies. They do have representatives from NGOs. But what notice the government agencies take is another matter; hopefully, it goes where it should end up. I think there is an attempt to get broad representation."
>
> NGO representative

To advise on the implementation of the Jamaican 1994–1995 *Policy for National Family Life Education*, a seven-member Family Life Education Interagency Committee recently formed. Two subcommittees (for the formal and nonformal sectors) began to meet in early 1998. To further Jamaica's *National Youth Policy*, Parliament passed an act to establish an interministerial committee on youth; the committee has yet to organize. One government representative said that the PPCC and the FPCC, rather than another special committee, should work on adolescent reproductive health. An interministerial committee was established in the late 1980s to ensure implementation of the 1987 *National Policy on Women*. The Gender Equality Commission, made up of government and NGO representatives, formed in 1996 under the aegis of the Prime Minister's Office.

NGOs

NGOs are not directly involved in population policymaking activities, although they participate in consultative meetings as well as some meetings of the PPCC. NGOs are represented on the NAC. According to one government representative, it is the job of the NFPB to coordinate with NGOs on policy

issues. "The NFPB is supposed to link with NGOs and the private sector. Subcommittees of the FPCC are supposed to have NGO and private sector representatives."

Women's advocacy groups, which have become more vocal, focused, and cohesive since the 1994 ICPD in Cairo and the 1995 Fourth World Conference on Women in Beijing, generally are not directly involved in policymaking, but they do advocate for special issues such as gender-based violence. The Association of Women's Organizations in Jamaica (AWOJA), established in 1988, is working on legal reform, including amendments to the domestic violence legislation that would cover sexual harassment (modeled after the CARICOM policy on sexual harassment). Rape and incest currently fall under the Violence against Persons Act, but AWOJA would prefer a separate rape and incest law.

Private Sector

The private sector is not involved in population policymaking, although professional associations, such as the Medical Association of Jamaica (MAJ) and the Nurses Association of Jamaica, work closely with the NFPB and the MOH on some issues. According to a representative from the MAJ, "The MAJ is trying to spearhead reform in the medical community. The council of the MAJ, which includes presidents of all the specialist areas, are fully behind the reproductive health initiative."

Local Level

With the exception of policy implementation, participation in the policymaking process has not yet filtered down to the parish level. According to Williams (1997), Jamaica does not have the mechanisms in place to integrate policymaking at the parish level. Nevertheless, the local levels generally support the policymaking process, but few actively participate in reproductive health policymaking, even when their local services are concerned. The MOH is in the process of enacting health reform, part of which includes devolution to the parishes; devolution may change the process of policymaking in the future. In addition, Parish Advisory Committees have been set up to ensure implementation of the *National Policy on Women*. Further, Parish Advisory Committees are being established as replicas of the NAC. They will be made up of public, private, and NGO representatives and will focus on advocacy, fundraising, and community mobilization.

B. Evolution of Policies from Family Planning to Reproductive Health

Jamaica initiated family planning services in the 1930s through a set of nongovernmental activities. In the 1963–1968 five-year plan, the government acknowledged the country's high rate of population growth and encouraged the spread of information and services for family planning (PIOJ, 1995a). In the late 1960s, the government formally adopted a family planning program and, in 1970, passed the National Family Planning Act and established the NFPB as a statutory board under the MOH. Until 1995, government policies on population focused on population size, fertility, mortality, external migration, and internal migration. In 1989, the PPCC began a process to assess the existing policy (last revised in 1983), in light of then current demographic, social, and economic conditions. According to a government representative who participated in the policy revision process, "Revisions of the population policy started as a part of the Cairo process, including discussions of gender, the aged, children, and the environment and development." The 1995 revised population policy did not make explicit reference to reproductive health.

At the same time, the PPCC developed the 1995–2015 *National Plan of Action on Population and Development*, which was designed to implement the objectives and recommendations of the 1995 (revised)

National Population Policy and the ICPD *Programme of Action* (PIOJ, 1995a). The plan includes a chapter on reproductive rights and reproductive health (including the verbatim definition of reproductive health from the ICPD) but is not a specific blueprint for action. Most statements indicate that Jamaica "should" do the recommended activities, but without specifying how.

> "I don't see anyone taking the responsibility for spearheading an integrated RH policy. There is recognition within the MOH that there needs to be a reproductive health policy, but there needs to be a term of reference for someone to take charge of reproductive health."
>
> Government representative

The PPCC has discussed developing a reproductive health policy but suggests that the NFPB and MOH—through the FPCC—submit a proposal for the policy. A subcommittee will be formed to develop the policy.[1] According to several persons, one obstacle to policy formulation is a lack of staff time. Two government representatives hoped that the United Nations Population Fund (UNFPA) or another donor would fund a position for a staff member to take charge of drafting the policy.

Until Jamaica develops a reproductive health policy, policies including those that follow will continue to cover the various components of reproductive health:

- *National Population Policy* (1995, revised from 1983), including family planning and maternal and child health;
- *National Plan of Action on Population and Development* (1995–2015), designed to implement the National Population Policy and the ICPD but does not provide specifics for action;
- National AIDS Program (1987), under which the NAC runs a strong STD/HIV/AIDS program through the Epidemiology Unit of the MOH despite the absence of national policy;
- *National Youth Policy* (1994), covering reproductive health information and awareness for responsible parenthood, breastfeeding, sex education and STD/AIDS, and the provision of proper health care for youth;
- *National Policy for Family Life Education* (1994–1995), providing guidance on conceptualizing, standardizing, and developing materials;
- adolescent reproductive health (in the drafting process);
- senior citizens (in the drafting process);
- women (drafting update of 1987 policy); and
- Violence against Persons Act (1995), including domestic violence, rape, and incest.

C. Definition of Reproductive Health

Respondents expressed considerable confusion over the definition of reproductive health. According to an MOH staff member, "When you say the words, different things come to people's minds." The same staff member added, "Reproductive health means the womb to the tomb. A holistic approach to women, men, and adolescents." A government representative said,

> "There is a need to bring together the components of reproductive health into a policy and program. There is a vision of how all these things should be, but no comprehensive policy on reproductive health, reproductive rights, and gender. Things are proceeding in a piecemeal way."
>
> Government representative

ficer for primary health care, the senior medical officers for MCH, director for nursing education for the MOH; and the executive dinator, and head of the IEC unit from the NFPB.

"Reproductive health isn't only genital organs, but is also mental and social." A representative from the private sector related, "I asked [a policymaker] to define reproductive health and that person spoke very broadly about it involving breastfeeding and women's health." A private provider offered a more complex definition. "The elements of reproductive health are debatable, but we should use the paradigm of reproductive health to integrate primary health care services in order to develop synergies and to utilize resources more efficiently."

As part of its terms of reference in becoming the Reproductive Health Coordinating Committee, the FPCC has drafted a definition of reproductive health for Jamaica in accordance with the ICPD definition: "A state of complete physical, mental and social well-being not merely the absence of disease or infirmity in all matters relating to the reproductive health system, its functions and processes." According to the terms of reference, still under discussion in late 1997, "No longer is the concern focused on family planning but a more holistic approach is being advocated which will involve:

- Meeting the needs of individuals and couples for a variety of safe and effective and affordable methods of fertility regulation from which they can make informed choice;
- Reduction of pregnancy-related morbidity and mortality as well as reduction of newborn deaths and disabilities;
- Prevention and management of reproductive tract infections, including HIV/AIDS and other sexually transmitted diseases; and
- The provision of services for the early detection and management of cancers and other conditions of the reproductive tract.

An integral part of this strategic change are the principles of dual protection, emergency contraception, and various gender issues. This approach encompasses the full life-cycle of men and women, although there is more emphasis on the vulnerable age group—the adolescent."

At the time of the case study, the above definition of reproductive health for Jamaica had not been widely shared. Some government representatives were surprised to learn that such a definition had even been drafted. Regardless of the definition of reproductive health and the status of reproductive health policy, Jamaica's main reproductive health priorities continue to be family planning and STD/HIV/AIDS; and as noted in the terms of reference for reproductive health, the age group to be targeted for services and activities is adolescents. One government official worries that donors, and consequently the government, are placing too much emphasis on adolescents. "Program discussions of reproductive health now tend to shift to adolescents. The vision should be to develop a comprehensive reproductive health policy with special emphasis on adolescents, but not only for that group."

D. Support and Opposition

Support for Reproductive Health

> "We have had sustained support from the government for population activities."
> Government

Since the 1970s, family planning has enjoyed strong support from the Jamaican government. Ravenholt and Clyde (1995, p. 8) paint a favorable outlook for family planning. "The overall environment for family planning in Jamaica is quite positive… today the prime minister… speaks of the importance of family planning service delivery to achievement of national development goals, and the government of Jamaica, through its Ministry of Health, makes family planning

services available to a significant portion of the population." Government support for AIDS activities has also been strong, with an increase in funding since the ICPD. An NGO representative commented, "Since Cairo, we don't have to fight with the government over the budget. We have the support of the highest levels of government."

Opposition to Reproductive Health

There is little opposition to family planning and reproductive health in Jamaica. Abortion is illegal, and both provider and client can be subject to prosecution for a criminal offense. Among reproductive health topics, the matter of adolescent sexuality and reproductive health services for young adults triggers the most vocal opposition. Some parents, teachers, administrators, and providers are particularly opposed to explicit sex education in the schools. According to a private provider, "Some schools don't want to deal with the topic of sex education, even with high rates of teen pregnancy. Also, talking to parents—they have their heads in the sand." A representative from an NGO noted that opposition to reproductive health information and services for adolescents is dissipating in the face of teen pregnancy statistics and the increasing prevalence of HIV and AIDS. "There is more acceptance by parents now, due to HIV. Parents are more aware."

Knowledge about Reproductive Health

> "Most of what we've done since Cairo is meetings and conferences. It is taking a long time to understand these issues."
>
> Government representative

Few people in Jamaica can define the term reproductive health, although program planners tend to be more knowledgeable than either high-level policymakers or providers. High-level policymakers tend to support reproductive health because of its links with development and poverty alleviation. According to a government representative who will participate in developing Jamaica's reproductive health policy, high-level policymakers are interested in learning more about reproductive health. She recounted, "In 1996, when I was participating in a meeting in cabinet on poverty alleviation, we started talking about adolescent pregnancy, which turned into a discussion about reproductive health. The cabinet wanted more information." A representative from the private sector was more skeptical. "I'm not sure that policymakers are aware of the links between reproductive health and the other issues they have to contend with." A representative from an NGO said that policymakers who attend international conferences such as Cairo and Beijing are far more knowledgeable than those who do not. "It makes a difference when a policymaker attends a conference. They are educated."

Government officials who are expected to design reproductive policies and programs are busy with day-to-day activities and do not think they have sufficient time to devote to understanding reproductive health. One government representative said, "Those most familiar with reproductive health aren't implementers. Those who went to all the conferences don't have time to put it all together. Implementers don't have time to read and internalize reproductive health. A lot of material on reproductive health exists, but people aren't going to read it." According to a donor representative, "When you talk to people here, it's still family planning even though people talk about reproductive health."

Private providers are becoming increasingly aware of reproductive health. In collaboration with Family Health International (FHI), the MAJ recently hosted a series of continuing education seminars for private physicians and other groups of providers, covering STDs and HIV, contraceptive technology, and

adolescents and reproductive health more generally. The theme for the MAJ's 1995 annual conference was women's health from pregnancy to old age; in 1996, the theme was men's health.

Despite some advances in the private sector, public sector providers are not yet knowledgeable about reproductive health as a holistic approach that treats clients as individuals with different reproductive health needs over the life cycle. According to a government representative, "There will be no change in staff and the clients will be the same, so we need to figure out how to get providers to see an individual person with his or her reproductive health needs." Some respondents said that providers receive training in reproductive health while others remarked that training is inconsistent and not widespread. "It's a lot of talk," said a government representative. "For example, we have a reproductive health survey instead of a contraceptive prevalence survey, but when it comes to telling people about reproductive health, I don't know if there is a structured program." Yet, even in the absence of a systematic program to inform providers about or train them in reproductive health, an MOH staff member is optimistic that staff understands the components of reproductive health. "To workers, reproductive health is a new concept. They probably wouldn't know how to define it, but they would know the individual elements." She added, "Some providers are starting to say reproductive health instead of family planning, especially doctors, midwives, and public health nurses."

Through the years, Jamaica has successfully instituted information, education, and communication (IEC) and advocacy activities focused on family planning and STD/HIV/AIDS. Knowledge among providers and the public about family planning and STD/HIV/AIDS is high. A PPCC subcommittee is devoted to IEC through the promotion of macro-level messages on population and development. The committee has produced materials such as a population magazine, videos, a stage play, and fliers. In addition, the NFPB has an aggressive IEC program that reaches people through radio talk shows, television, newspapers and other written materials, training programs, and other outreach programs. AWOJA participated in a publicity campaign on domestic violence (it worked with its partner organizations, Women, Inc., Sistren, and Women's Media Watch). AWOJA also publicized the 1995 Violence against Persons Act. According to an NGO representative, "Beijing helped promote the domestic violence bill in particular. After Beijing, women's issues came more to the fore. At least in Kingston, the person on the street might have heard of Beijing. The press did local interviews about it." The Bureau of Women's Affairs also promotes changes in the status of women. According to a government official, "Mythologies work against women in our society. We are doing public education, talk shows, and are trying to show that what's common sense is nonsense." According to an NGO representative, "The conferences—particularly Beijing—raised public awareness."

The National AIDS Program is also distinguished by a strong information and outreach component. According to Dr. Calderon of FHI's AIDSCAP Project, "Jamaica established one of the most comprehensive behavior change communication campaigns we have seen" (Henry, 1997, p. 19). The campaign clearly defined target groups (e.g., men and women entering new relationships, women in need of condom negotiating skills, men with STDs, and women with STDs) and tailored messages to their needs. The communications program has been so successful that it is difficult to go anywhere in Jamaica without seeing or hearing a message about AIDS—whether printed in newspapers and magazines and on bumper stickers, broadcast on television and in videos, performed by dance troupes, or mentioned in songs played by the latest dance hall disc jockeys. The National AIDS Program encourages condom use and is trying to make women aware of silent symptoms. The messages are clear: use a condom with every sex act; be aware of sexual networks; and abstain or stay with one uninfected partner. Dr. Peter Figueroa, head of the National AIDS Program, reported that "awareness of AIDS and how it is prevented is high (over 90 percent), and condom use has increased (1994, p. 2)." According to Henry (1997, p. 22), "The majority of the population now reports some behavior change to avoid HIV infection."

Some respondents noted the need for a coordinated effort to inform providers and the public about reproductive health. One government representative noted, "We need a plan to integrate IEC and services and definition clarification for providers and the public." Another government respondent added that the various IEC committees and departments (in the PPCC, the NFPB, and the MOH) should work together to publicize reproductive health. "We need to link IEC activities so that we are all giving the same messages." A government representative commented, "We need to sell reproductive health as important to people's lives."

4. Policy Implementation

A. Operational Policies and Plans

> "We haven't gotten off the mark on these programs. We have the best intentions in the world, but we have trouble keeping up with all these deadlines from international conferences. Our desks are full."
>
> Government

One NGO representative commented that "Cairo wasn't an earthquake for us. It wasn't anything new." Another NGO respondent said that Jamaica tends to be an initiator of activities in the Caribbean. Other respondents noted that the ICPD did have an effect on programming for reproductive health. A government official said, "Cairo came along at a time when we were ready to make changes in the program, but if it weren't for Cairo, we wouldn't be making the program changes." Yet, even with the development of documents such as the 1995–2001 *National Plan of Action for Population and Development*, Jamaica to date has not formulated explicit operational plans to implement reproductive health activities. According to a donor representative, "Jamaica did a lot to support ICPD, but the translation of those programs back home has been spotty. It hasn't taken off. We all fell into the trap of just changing the name from family planning to reproductive health." Another donor representative remarked, "I haven't seen any changes in programs."

B. Service Delivery Structure

Family planning and the other elements of reproductive health are available through the public, NGO, and private sectors. Jamaica's public health care system is relatively well developed with a network of more than 350 public sector and NGO health facilities islandwide, in addition to private sector facilities. According to a mapping study of Jamaica's family planning service delivery points (SDPs), the public sector operates 63 percent while private providers operate 30 percent and NGOs about 7 percent (Bailey et al., 1994). With some exceptions, the private sector and NGOs work predominantly in urban areas; the public sector health facilities serve both urban and rural populations. At least for family planning and STD/HIV/AIDS services, the public sector predominates.

The public sector has designed a three-tiered administrative system for primary health care: national, regional (Western, Southern, South-east and North-east), and parish. The island is organized into 14 parishes, which are further subdivided into health districts. Within this structure, five types of health facilities offer graduated levels of service. Types and levels of service have implications for integration of reproductive health services. A Type I health facility offers the lowest level of service, whereas a Type V offers the highest. Type I centers provide basic MCH, nutrition, immunization, and family planning services (MOH and NFPB, 1991). Type I centers are staffed by a midwife and community health aide.

Type II centers are staffed by a public health nurse. Type III centers serve as magnet units for each health district. Type IV centers, which administer parish health programs and house parish administrative staff, offer specialist services, such as treatment for STDs and more complex family planning services. They include community hospitals and rural maternity centers. Type V centers are based in large urban areas (Bailey et al., 1994). Some services are available in satellite clinics that operate at infrequent intervals. Some components of reproductive health share clinic space and clinic days with other health programs; others share clinic space but operate on different clinic days; and others operate independently of any other health program in either separate buildings, or the same building in separate quarters.

C. Implementing Agencies and Actors

Various divisions of the MOH administer the components of reproductive health (see Table 1). In addition, NGO and private sector outlets also provide some components of reproductive health.

Table 1. Coverage of the Components of Reproductive Health in Jamaica

COMPONENT	LOCUS OF ADMINISTRATIVE RESPONSIBILITY
Family planning	MOH/PHC/MCH, NFPB, NGOs, private providers, social marketing program
Safe pregnancy	MOH/PHC/MCH, NGO, private providers
Postabortion care	MOH/PHC/MCH, NGO, private providers
STD/HIV/AIDS	MOH/EPI, NGO, private providers
Cancers	MPH/PHC and SC/gynecology services, NGOs, private providers
Infertility	UWI/FMU, private providers
Adolescents	MOH/PHC/MCH, NFPB, NGOs, some private providers
Men	Not a focus of any program in the MOH; access to condoms is not a problem; NGOs, private providers
Violence	External to the MOH. Crisis centers for domestic violence operate only in Kingston and Montego Bay. The MOH is involved with medical examinations in rape cases for the Ministry of National Security. Domestic violence and rape statistics unavailable.
Reproductive rights	Locus of responsibility is unclear. NFPB has been advocating for youth reproductive rights through a series of national forums with youth

Notes: PHC—Primary health care; MCH—Maternal and child health; EPI—Epidemiology Unit; SC—secondary care; UWI/FMU—University of the West Indies/Fertility Management Unit

While all the elements of reproductive health are available in Jamaica, all services generally are not available together in one location. Some clients might have to travel to obtain some services (e.g., STD treatment, cancer screening, and infertility). The most well-developed elements of reproductive health are family planning, MCH, and STD/HIV/AIDS. Family planning and MCH services are accessible to most Jamaican women, although, as discussed in more detail below, the family planning program does not adequately meet the needs of adolescents and men. In the past five years, the NFPB has focused its efforts on increasing contraceptive use; reorienting the family planning program to a heavier reliance on the private sector instead of the public sector; facilitating a shift in contraceptive method mix to longer-term and permanent methods (particularly IUDs, injectables, and sterilization); improving its system of supplying contraceptives to MOH clinics; and promoting IEC. With assistance from the U.S. Centers for Disease Control and Prevention, Jamaica has strengthened its logistics system for contraceptives; that system is now considered to work exceptionally well. The MOH and the NFPB have also been working to improve

the quality of care in clinics, particularly through training programs for providers in the public and NGO sectors.

Jamaica's family planning program has long had a strong program in the social marketing of contraceptives. Until 1993, the NFPB operated the program. Now implemented in the private sector with assistance from the SOMARC Project of The Futures Group International, the program is called the Personal Choice Program. To increase access to contraception, the government has been working to secure over-the-counter status for pills. Apparently, over-the-counter status has been approved and was to be gazetted by the government in early 1998. In addition, the government is working to increase access to contraceptives at new outlets.

National AIDS Program

Jamaica has built a comprehensive National AIDS Program in the past decade. According to a government representative, "We have had an STD program for 30 years, but with HIV and AIDS, there is no room for complacency." The director of the program comes from the Epidemiology Unit of the MOH (referred to in Jamaica as the EPI Unit). Services are provided at PHC/MCH centers that incorporate specialist STD clinics.

The EPI Unit tries to ensure a steady supply of STD drugs at the PHC centers in order that providers can deliver first-line treatment and make referrals as necessary. At major antenatal clinics, women undergo syphilis tests during their first visit. With new decentralized STD laboratories, parish clinics can get results of syphilis tests more rapidly than in the past. For HIV, the National AIDS Program makes available drugs to treat opportunistic infections. Contact investigators work in the community to stop the spread of STDs, including HIV. Pregnant women receive AZT (Zidovudine Retrovir); others are treated for opportunistic diseases and are given nutrition supplements and encouraged to lead healthy lifestyles. Antiretrovirals are available for people who can afford them. The NAC is hoping to attract clinical trials of AIDS drugs to Jamaica. The NFPB procures and distributes condoms for the AIDS control program.

Behavior change communication is a cornerstone of the National AIDS Program. According to a government representative, "At present, there is still a low prevalence of AIDS—people are just beginning to put a face to AIDS. We need to continue to promote behavior change." As a result of the National AIDS Program, condom use has soared from 2.5 million in 1985 to 10.5 in 1995, and an expected 20 million in 2001. "People are using condoms now because they are scared of HIV," according to an NGO representative. The 1993 CPS found that virtually all of the increase in contraceptive prevalence, from 56 percent in 1989 to 63 percent in 1993, was attributable to an increase in condom use, which grew from 9 percent of women age 15 to 44 in union to 17 percent (McFarlane et al., 1994). In 1997, too, 17 percent of women reported that the condom was their primary means of contraception (McFarlane et al., 1998). In 1997, 11 percent of women age 15 to 49 reported that they were using condoms as a secondary method in addition to their primary method. USAID is supporting a project that employs a condom marketer and funds parish-level behavior change officers. At the end of the project, the government will take over these posts.

NGOs and the Private Sector

NGOs do not serve a large percentage of reproductive health clients in Jamaica, but their services tend to be of good quality—and more innovative than public sector services, which are slower to change. At the Family Planning Association of Jamaica (FAMPLAN), the International Planned Parenthood Federation affiliate in Jamaica, "Activities have broadened in scope since Cairo. We had been doing reproductive

health before, but ICPD made it more urgent." At FAMPLAN's two clinics in Kingston and St. Ann and through its outreach programs and satellite clinics, services are expanding to include better counseling; integrated family planning and STD/HIV/AIDS services; a focus on youth and men; and community participation. In addition, FAMPLAN will begin implementing a domestic violence project in 1998. FAMPLAN is receiving an increasing number of requests to talk to community groups. "Forums for STDs are growing. In the last month, I've been asked to make four presentations in the area," said an NGO representative.

A number of other NGOs, such as Operation Friendship, VOUCH, and the Women's Resource Outreach Centre (WROC) operate health clinics. WROC, for example, runs a women's well-being clinic in Kingston once a week. Men and children also use the facility. In 1998, WROC plans to add cancer screening for women and men. It would also like to expand services to more days and operate a special clinic for men's reproductive health.

The NFPB, the MOH, and the MAJ are encouraging private physicians to provide reproductive health services. A 1993 study of the family planning service delivery practices of private physicians found that their contraceptive care was inconsistent with the most up-to-date scientific information. In addition, some private physicians who had not received training in counseling clients for contraceptive use were nonetheless doing so. The private physicians said they would be interested in a range of training related to contraceptives and counseling (Hardee et al., 1995). In fact, private providers have been receiving training in family planning and other aspects of reproductive health care through activities such as the Continuing Medical Education series on STDs and contraception sponsored and conducted by the MAJ, the NFPB, the EPI Unit, and FHI. In addition, the NFPB pilot project for private physicians provided training and computerization to a number of private providers through the UWI/FMU. USAID donated the computers for the purpose of setting up a management information system to help follow up with the physicians. The EPI Unit has encouraged private sector involvement in all activities related to STD/HIV/AIDS—not just treatment. The private sector has improved its reporting of STD cases.

D. Integration

Integration of Family Planning into MCH Services

When considering the possibility of broadening the integration of reproductive health services, one donor representative concluded, "The service delivery structure is vertical. There isn't a group in government that is willing to bring it all together with referral and linkages." A government representative concurred. "Institutions are worried about turf and keeping their institutions in place. Can you integrate without making structural changes? Do you change management structures?"

> "In my experience, it takes years to make changes. We are making progress getting people to think about integration."
> Government representative

Family planning is integrated into MCH services at all levels of the service delivery system (e.g., at Types I through V clinics). The 1995 quality of care study in public sector and NGO clinics found that providers are responsible for a range of MCH and family planning counseling and services (McFarlane et al., 1996). Said one government representative, "Integration takes place at the service delivery level. Maybe family planning and MCH services are offered on different days, but the staff is the same. Clients need to know which days to get which services." According to a government representative, however, "Twenty-five years after integration of family planning and MCH, some service providers still

think family planning is an add-on." That perception is not helped by the fact that providers used to receive additional fees for providing family planning services, a practice that stopped years ago.

Integration of STD/HIV/AIDS into Family Planning

The EPI Unit of the MOH directs STD/HIV/AIDS activities. A government representative offered, "The Epidemiology Unit in the MOH works vertically with the MCH clinics on STD and HIV activities. They have a lot of contact investigators. Their approach has been that they need the EPI Unit to overcome the MOH bureaucracy." Indeed, some discussions, including a December 1997 National AIDS Program meeting on monitoring and evaluation, have focused on integrating STD/HIV/AIDS services into family planning services in the public sector. According to a government representative, "Realistically, we should start with the big ones—then it will be easier to integrate other reproductive health elements." Despite some linkages between family planning and STD/HIV/AIDS services, services are inconvenient for clients. The study on quality of care in the public and NGO sectors showed that most providers say they counsel clients about STDs and HIV/AIDS, although few of the simulated clients who attended the clinics for the study said they were told much about STDs or HIV (McFarlane et al., 1996). A government representative reported, "If a client has a discharge, she may be told that the STD clinic is on Wednesday. But it may be a yeast infection." The dual-method study showed a significant problem with STDs among family planning clients (Behets et al., 1997).

With funding from the Pan American Health Organization, the North-east is a pilot region for the integration of family planning and STD/HIV/AIDS services (but not administration of the activities within the MOH). Said an MOH staff member, "The MOH has formalized use of the syndromic approach through a pilot project in the North-east region. A workshop was conducted in St. Ann to train providers on the syndromic approach. They give treatment on the spot. There was a problem with drugs, but they are working on prepackaging the drugs. They use the RPR test, which can be done right away." One government representative noted, however, "I don't think they are using the syndromic approach (treatment without testing) right. There are limitations to that approach—there is a need to refine the algorithms."

Jamaica faces several challenges to the integration of STD and family planning services, including identification of the scope of integration (e.g., administrative and service integration, involvement of specified levels of the service delivery system, and complete integration versus linkages). For example, a government representative noted, "If a rural woman wanted STD services, she would have to go to one of a few Type V centers for treatment. Maybe she could go to a Type IV center—they have labs. Once she has seen a doctor, she can get treatment (most health centers do not have doctors on staff). In the absence of an STD center, if she goes to a doctor she can get treated." Some contact investigators are also using the syndromic approach to treat clients. She added, "The services in Types III, IV, and V (including community hospitals) are quite comprehensive, but I am not sure they are doing everything at these clinics in terms of STD services for family planning clients."

A government representative cautioned, "We need to be systematic about the integration. For example in policy, do we advocate dual-method use? For services, is the set up okay to do private counseling? We need to strengthen STD case management to make the right diagnosis and the right treatment. We need to promote risk reduction through the right behavior. For training—do providers have the counseling training necessary? For monitoring and evaluation—are all the forms and checklists available to make sure all the steps are followed? For IEC—is it designed to speak to integrated aspects of reproductive health? Have we educated the public about what services they should expect and have the right to? Have referral services been strengthened? Should we have specialists in the PHC clinics once a month to take referrals?"

Another government representative agreed. "I'm not even sure if the monthly clinic form has any provision for capturing who the clinics are seeing for STDs and who they are referring (like for tubal ligation)."

Other issues pertain to the integration and training of staff. One government representative noted, "Contact investigators are a separate category of staff, under the EPI Unit. They are not necessarily cross-trained in family planning, unless they are nurses or midwives. They do a lot of work with the HIV/AIDS cases. But the contact investigators are now more integrated into the clinic team." Another government representative commented, "Providers think adding services takes too much time. They would rather refer than to try to provide the service themselves." Family planning and MCH providers are used to working with women who are having babies or who need family planning; providing services to women—and men—who might have STDs or HIV/AIDS might require a change in attitudes of many staff members.

The government can learn from FAMPLAN, which participated in a program between 1993 and 1996 to integrate STD prevention and treatment into family planning services. As a result of the project, "the typical counseling session had evolved from mainly informational into a real exchange between counselor and client that explored the client's needs within a sexual and reproductive health context" (Becker and Leitman, 1997, p. 3). The key to FAMPLAN's success was extensive and participatory training for providers, many of whom needed to break down their own biases against STD clients. The program led to increased condom use and did not take more time on the part of workers, who had worried that their workload would increase.

E. Gaps in Coverage

Some respondents noted that reproductive health services are noticeably inadequate in meeting the needs of menopausal women, men (particularly screening for prostate cancer), adolescents, and drug users. According to a private provider, "We have a group of doctors who want to set up a menopausal society in Jamaica. Wyeth-Ayerst will fund it." Adolescents are a major target for policies and programs, and programs for men are undergoing development (discussed in more detail below). Infertility is the newest focus in Jamaica. According to a private provider, "Couples having difficulty conceiving have been ignored in the country over the past 35 years. Diagnostic work has been done, but not treatment." In response, the UWI/FMU has built a new clinic that will provide treatment; previously, clients had to travel to Miami or elsewhere. The clinic will also provide reproductive cancer screening and treatment.

The delivery of some reproductive health services is linked to a client's need for and use of family planning services. For example, "If a woman is not a family planning acceptor, or if she doesn't have some other reason to be seen, I don't think she can just go in and get a Pap smear. We are trying to move to a more organized approach so that all women under age 65 can get a Pap smear. This program is starting as a large pilot. Nearly every parish has four centers offering such services. There is a small fee, like J$50," according to a government representative. [2]

Timeliness of services has also been a problem. A 1995 study of the quality of care in public sector and NGO clinics found that providers routinely tell clients to return for services when they are menstruating, often without providing any counseling on family planning or STDs. Such a practice poses a problem of access for clients who must travel to clinics that offer family planning on certain days of the week (McFarlane et al., 1996). According to a government representative, "For cervical cancer screening, timeliness of reports is a problem. It takes two months to get back the results of a test. We are trying a

[2] In December 1997, US$1 = Jamaican$34.5.

pilot project to speed up the reporting. The treatment of cancers isn't a problem. It becomes a priority for being seen once it is diagnosed. For example, the Kingston Primary Hospital holds three gynecology clinics a week. Empty spaces are left for emergency cases. Access to colposcopy in rural areas is a problem sometimes. We try to link clinics with the cancer society or with gynecology units in hospitals. We want to train general practitioners to do colposcopy in the North-east region, which is a pilot region for integrating STD and family planning services."

Reaching Men

> "A lot of countries in the Caribbean think that Cairo's focus on women is too narrow—that gender includes more than just women."
> NGO

Despite the recognized importance of the role of men in their own and their partner's reproductive health, few programs reach men. The university has services for men and recently sponsored a meeting on men's issues. In the public sector, "Within the family planning clinic setting, little is done even in terms of routine exams for men," according to a government representative. Marge Roper, a counseling program affiliated with the NFPB, provides counseling for men, whereas Fathers, Inc., promotes male responsibility in fatherhood. Although its goals are modest, the Personal Choice Program promotes vasectomy for men. FAMPLAN recently started conducting a male clinic one night a week in one of its own clinics; services focus on diabetes, hypertension, and prostate cancer. According to an NGO representative, "The clinic is popular. Some of the same men come week after week. Part of it is discussion. These men don't have anywhere else to go for this information."

Discussion sessions for men are good, said a private provider. "We need to change men's attitudes on reproductive health and on family planning methods. Their only method is the condom, but men have an attitude against them. We need a comprehensive health service where men and women could come. We could stagger hours. We need to dispel myths. Some men still beat their women for using family planning. I've seen women come in battered and bruised because they've asked too many questions. A lot of it is just ignorance." An NGO representative asked, "How can we get males involved?

Little research on reproductive health has involved men in Jamaica. Notable exceptions include a 1991–1994 national study of sexual decision making among Jamaicans sponsored by the AIDSCAP Project of FHI (Wyatt et al., 1994) and a longitudinal study of sexual attitudes and behavior among young adolescents (age 11 to 14) sponsored by the Women's Studies Project at FHI (Jackson et al., 1997). The World Health Organization (WHO) is supporting a study being conducted by the UWI/FMU on the male perspective on unplanned and mistimed births. It will include 700 males age 15 to 49. However, still more research on men's perspectives in reproductive health is needed.

Special Focus on Adolescents

Despite a long-time awareness of Jamaica's teen pregnancy problem, the issues of adolescent sexuality and reproductive health services were politically sensitive topics until only recently. According to an NGO representative, "Previously, people focused on adolescents, but they were not a government priority. There are statistics showing that school drop outs and pregnancy rates are high. Also, the crime rate is high." Even though adolescents are now a government priority, one respondent noted the conflicts among norms, values, laws, and behavior. A longitudinal study of young adolescents (age 11 to 13) who were at high risk for early sexual activity reported, "These Jamaican adolescents' sexual attitudes and behavior have already been significantly shaped by sociocultural and gender norms that send mixed messages, particularly to

girls, about sexuality and impose different standards of behavior for boys and girls. Boys perceive social encouragement and pressure to be sexually active, while girls who have sex, especially if a pregnancy reveals their sexual activity, are branded as having inferior moral standards" (Eggleston et al., 1997, p. i). Past studies of older youth have reached similar conclusions (Brody, 1981; Donoghue, 1993; Jagdeo, 1984). According to Wright, Blumberg, and McKenzie (1995, p. 7) in an evaluation of the USAID 1991–1998 bilateral family planning project, "It is clear that this group requires massive and personal interventions to prevent pregnancy, especially in the context of Jamaica's culture in which sexually explicit TV and soap operas, advertising and music, and the reduction in the age gap between parents and children contribute to early sexual activity among boys and girls." The *National Youth Policy* broadly covers issues related to young people. In addition, the MOH is drafting an adolescent reproductive health policy. Noting that 25 percent of births are to teenagers in Jamaica, a donor representative remarked, "The statistics show that there is a need to work with adolescents age 15 to 24."

Historically, the health system has not served adolescents. According to an NGO representative, "Traditionally, adolescents have fallen in mid-air in the health system. Children are treated and married people are treated. The CPS showed that there is a gap between knowledge and practice. Statistics have shown the cracks. The quality of care study showed that providers are more reluctant to give contraceptives to girls than to boys." Several government and NGO representatives pointed to the deficiency in parenting skills among teen parents. One government respondent commented, "The family planning program is emphasizing individual choice [through the Personal Choice Program] but adolescents fall into a gray area." A private provider remarked, "I see pregnant girls age 13 to16. Some say they haven't heard of family planning, or that they were on the pill but didn't remember to take it, or they were experimenting. None are happy to be pregnant. Thank goodness we have a good branch of the Women's Centre here. We need to provide adolescents with access to accurate information and services."

One legal barrier is the age of consent for adolescents, which is age 16. An NGO representative noted, "We've been dealing with the age of consent issue for a long time. Now, if consensual sex is under age 23, the judge has the discretion in sentencing. Before, if the female was 16 or below, there was a mandatory three-year jail sentence for the boy." The government is also trying to get special dispensation for providers to allow them to dispense contraceptives to adolescents.

For 20 years, the Women's Centre of Jamaica Foundation has been operating a program intended to help pregnant girls have their babies and stay in school (Barnett et al., 1996). The program faced opposition when it started in 1978 but is now considered a highly successful teen program. Among the more than 16,500 girls who participated in the program from 1978 to 1994, most returned to school after their pregnancies. The Women's Centre, with one center for every two parishes, reaches 52 percent of the girls 16 and under who become pregnant. Given that some of the young mothers have to travel long distances with their babies to reach the center every day, demand could sustain one center per parish. According to an NGO representative, "There are tremendous odds against the girls coming to the center every day." The Women's Centre provides peer counseling training each summer. Schools are finally getting the message and are referring good rather than trouble-making students for training. "It takes time to change the attitudes of staff." The Women's Centre wants to become an examination center where pregnant girls could take their school examinations. The social welfare fund is setting up a center in Morant Bay, and the Women's Centre is always looking for additional funding for centers and programs. The Women's Centre runs a clinic for adolescents in Kingston. According to an NGO representative, young adults like to have their own clinic.

"The amount of money that has been wasted on FLE! The MOE is closing their eyes to the problem."
NGO representative

For more than 20 years, Jamaica's schools have been providing family life education

"We've been talking about FLE in the Caribbean for more than 20 years. I hope reproductive health isn't like that."

(FLE), yet the program still draws criticism from all quarters for its weaknesses. Of the multitude of curricula for school-based FLE, most teach students about reproductive health in only the most general terms. Moreover, standardizing and updating the FLE curricula had been a political issue until recently. According to one respondent, "Principals have authority over what gets taught in their schools, but they aren't involved in the FLE development, nor are parent groups or religious groups." At a recent CARICOM meeting of education ministers, a policy decision called for standardizing and strengthening FLE. As an NGO representative noted, however, "Implementation is another story." Still, policy and advocacy work on FLE over the past several years led to the 1994–1995 *Family Life Education Policy*. Various organizations have evaluated curricula over the years. Currently, a consultant is developing prototype materials on FLE for teachers colleges.

According to an NGO respondent, "FLE tends to be for lower-age children—primary and all-age schools. FLE is available at high schools, but each school organizes its programs individually and there are several problems with it. We need to do research to find out what exists. Training of the teachers is a sore point." The Child Health and Development Project, for example, is geared to children up to age 12. The curriculum for grades one to three is well developed (sex differences and changes), but the project is still developing the curriculum for grades four to six (sex and reproduction). An NGO representative described another curriculum. "We have a volunteer group called parenting partners. We've developed a two-volume set of materials and have trained schools, but it hasn't been evaluated yet."

USAID is currently funding an Adolescent Upliftment Project, comprising four components: reproductive and sexual health, literacy, FLE for personal development, and remedial skills-development training. The project is not intended for schools but rather serves both in-school and out-of-school youth. USAID is also in the process of developing a new adolescent reproductive health project for Jamaica.

In addition, UNFPA is designing a pilot project for adolescents in three Caribbean countries (Guyana, Jamaica, and Suriname.) The project, which will work through youth centers, schools, and training centers, will focus on family planning, STD, and skills and empowerment training. Training for program staff and providers will include the nonmedical aspects of adolescent issues. In Jamaica, the project will be located in Kingston, rural Trelawney, and Montego Bay.

F. Constraints

Institutional

Since the mid-1970s, the health sector, like other sectors, has come under increasing financial pressure. During that time, "partly as a consequence of the severe financial situation experienced by the MOH, attention has been paid to improving the efficiency and cost-effectiveness of health services, while endeavoring to ensure a reasonable quality of care" (Walker and Wint, 1987, p. 520). However, management and staffing issues have continued to affect Jamaica's health care system. The MOH is currently undergoing health care reform, including reorganization of the ministry as recommended by WHO. As a result, MOH staff have voiced some confusion about where reproductive health will be lodged within the bureaucracy. According to one government representative, "WHO is pushing a reorganization along the lines of family health. There is confusion about the differences between family health and reproductive health, which will fall under the Division of Family Health."

Human Resources Development

In the public sector, staffing shortages and staff turnover have adversely affected PHC centers. In addition, providers have not been trained to take a holistic, life-cycle approach to clients or to provide the integrated elements of reproductive health. According to a government representative, "Workers aren't linking the points of reproductive health. In training projects, we are trying to get them to make the connection." Said another government representative, "They have to make the linkage in their minds before they'll provide the services." A third government representative commented, "Providers haven't started looking at clients as individuals—looking at the whole health of the individual." Therefore, "Clients are referred rather than providers trying to do the services themselves."

A government representative highlighted the "need to train all providers in reproductive health, advocacy, data collection, counseling/peer counseling, and gender sensitivity." A donor representative agreed, "There is a need for revamped training." Some respondents pointed to changes in training "to increase awareness of reproductive health among providers, but services haven't really changed." It appears that the changes made in training have not been systematic but have instead primarily occurred through meetings and continuing education. According to a government representative, "We do regional updates for MOH staff. Last month we spent an hour on reproductive health in one of the regions." Another government representative said, "Training on reproductive health is supposed to occur in the four health regions. Funding is a problem, so it has only occurred in the South-east region. Midwives and nurses have periodic updates, which include reproductive health. And it is discussed during staff meetings."

Another human resources issue centers around the categories of staff that receive training. A provider said, "We have focused on doctors, but now we need to train nurses, guidance counselors, and others in the community, including church groups." A government representative commented, "Part of the problem is that we concentrate on training nurses, but it's the midwives and community health aides (CHAs) who are in the clinics. They are the link to the community." An MOH staff member responded, "But the nurses have to maintain the standards. They are the supervisors." An estimated 80 percent of nurse practitioners are trained in the syndromic approach to treating STDs. A government representative noted that "CHAs are also trained at an appropriate level for their duties, but they complain they have too much work." Other categories of health workers are demanding training. According to a government representative, "We have public health inspectors asking for reproductive health training."

Preservice training has not changed to reflect a reproductive health focus. One NGO representative noted, "The School of Nursing has its own curriculum, but Cairo probably hasn't changed it. They are aware of Cairo, but they think they are already doing it." A government representative said that expanding the coverage of existing training curricula is not easy. "The MOH is asking for the curriculum in the midwifery school to be revised to include reproductive health. But that has implications for the timing of the course. If reproductive health is added, something has to be taken out. The nursing council would have to decide."

The UWI/FMU operates a distance learning program (UWIDITE) for providers throughout the Caribbean. With funding from UNFPA, the UWIDITE program includes courses on the components of reproductive health that deal with safe pregnancy, ante- and postnatal care, breastfeeding, cancers, infertility, men, adolescents, child neglect, STD/HIV/AIDS, counseling, and program management. No courses cover abortion. UWIDITE has tried to minimize overlap between courses. One criticism of the program, voiced during an evaluation of UWIDITE in 1997, is that participants taking the courses individually might not develop a complete overview of reproductive health. FMU is considering merging the courses into a certificate course in reproductive health. However, with the university phasing out certificate programs, it is not clear if a graduate-level certificate program would be feasible. In response to the evaluation, the FMU is designing a program for a masters degree in counseling. Reaction to the distance learning program

has been positive. According to the program evaluation, "…all countries requested the continuation of Reproductive Health Courses via the UWIDITE system" (FMU, 1997). More participants, "especially nurses, and social workers—the one's who need it," would like to attend the training programs, but they cannot afford the tuition, according to an NGO representative.

Coordination among Organizations

Several respondents noted that coordination at both the policy and program levels is a constraint to implementing reproductive health programs in Jamaica. Planning processes in ministries are not always linked with those of the PPCC, which does not always keep the population community informed of its activities. A private sector representative remarked, "The messages from the PPCC do not get disseminated. I don't know what they are doing. I wish there was a better way of keeping everyone involved." Coordination between the NFPB and MOH could be improved. Institutional turf issues sometimes affect working relationships between the two organizations. One government representative added, for example, that the MOH might not be willing to accept a reproductive health policy or program if it were perceived to have been developed by the NFPB.

Respondents noted the need for enhanced coordination among the IEC committee of the PPCC, the IEC department of the NFPB, and the materials unit of the MOH. One respondent suggested that perhaps some functions could be merged to avoid overlap. According to a government representative, often one group does not know what the others are doing.

Coordination between the central office of the MOH and the parishes is also less than optimal. Said one government representative, "If something is developed by the MOH and disseminated to the parishes, then everyone will have the same idea and they will implement it." Coordination among staff is also a constraint. A government representative stressed that nurse practitioners, the district medical officers for public health, and the public health nurse need to work together to ensure integration.

Lack of coordination among donor agencies is yet another constraint. According to a private sector representative, "I'm a little disturbed by the lack of linkages among donor agencies. I can even see it working in the adolescent area. Everyone wants to be there first and be recognized most." An NGO representative echoed this sentiment. "At a recent meeting on adolescents in 1997, UNFPA, UNICEF [United Nations Children's Fund], and USAID were there. That was the first time I'd seem them together at a meeting."

> "We need better integration of funding agencies and better collaboration. They have different policies and objectives, which leads to duplication."
>
> NGO representative

Coordination with women's groups also lends itself to improvement. For example, AWOJA could be more closely linked with the NFPB. Until now, it has not had the staff or the opportunity; recently, however, it received three to five years of seed money from the German government. An AWOJA member noted that she sees a lot of MOH clinics that are closed when they should be open, especially in rural areas. She and others noted that AWOJA could help advocate for reproductive health in general or, more specifically, use the association's channels to lobby for more staff or opening the often-closed clinics.

Funding

Most respondents indicated that funding for reproductive health activities was a constraint to increasing programs. A government representative noted, "Countries promised at ICPD, but they haven't delivered."

Many respondents concurred. "We could do more if we had more funding"—whether for training providers, extending services to youth and men, expanding access to more elements of reproductive health or developing and disseminating more materials. A donor representative disagreed, saying, "There are a lot of resources already in the system." An optimistic government representative remarked, "If people buy into reproductive health, the funding should come."

5. Resource Allocation

A. Funding Levels for Reproductive Health

From 1994–1995, the MOH received 5.8 percent of the national budget compared to 6.7 percent in 1989–1990 (Wright et al., 1995). Family planning has no special earmark in the national health budget, and there are no extra funds for reproductive health activities outside the budget for primary health care. No government representatives could indicate the levels of funding for reproductive health activities. As donors reduce their funding in Jamaica, the government is picking up some of the expenses. For example, the government now pays for contraceptives—an expense covered by USAID until recently. With health sector reform, the future of the health budget remains unclear. UNFPA estimates that Jamaica will require nearly US$10 million in 2000 and US$10.7 million in 2015 to meet the goal of universal access by the year 2015 for those couples and individuals likely to use family planning and reproductive health services (UNFPA, n.d.).

B. Major Donors

Donor support has been declining in Jamaica in the past decade. The World Bank has not provided funding in Jamaica since 1994. USAID, which is the largest donor in Jamaica, has nearly completed its phaseout of funding for commodities. USAID's bilateral family planning project, which provided significant support to the NFPB, concludes in mid-1998. UNFPA is providing Jamaica with less funding, with the available resources now allocated to youth programs. USAID is also concentrating most of its reproductive health resources in adolescent programs. In addition, USAID is funding an AIDS project. The German Technical Corporation helped set up HIV referral laboratories in Jamaica and is funding communication officers in St. Catherine. It also funds an AIDS surveillance system. Debt-swap funds through the Jamaica Environment Fund are underwriting a Child Survival Project. UNICEF also funds child survival activities in Jamaica. FAMPLAN receives one-third of its funding from the International Planned Parenthood Federation; in addition, the Canadian International Development Authority is funding a small FAMPLAN project.

Some respondents noted that programs in Jamaica tend to be donor-driven. A private sector representative said, "Projects tend to be driven by donors in these economic times. Now their emphasis is adolescents." A government representative added that donor agendas affect the ability of organizations to collaborate on activities. "We are donor-driven in the sense that there are timelines—agencies have to get the work finished in a certain amount of time—institutions don't have time to collaborate with other agencies in Jamaica." Said one government representative, "You can't blame the government for lack of funding in programs because up until now, there has been so much donor funding."

C. Financial Sustainability

All respondents spoke about the need to increase the financial sustainability of reproductive health services in Jamaica. The government has shifted to the private sector family planning users who can afford to pay for needed services; still, the MOH is committed to providing at least a 40 percent safety net of free services. The MOH has implemented a successful cost-recovery program for hospitals, but has no plans to extend it to primary health care. Despite talk about a national insurance scheme, such a system would apply only to hospital coverage. Some respondents were concerned that the NFPB does not receive a higher level of funding from the government. One respondent said, "The NFPB is now being required to fund their own activities but they don't really have the capability and they shouldn't have to. Other statutory bodies get funding. They are now competing with other reproductive health organizations for funding." One NGO representative suggested that family planning and reproductive health activities should be beneficiaries of the lottery.

FAMPLAN is also seeking ways to improve its financial sustainability. It currently has 60 percent cost recovery in its clinic in St. Ann and 50 percent in its clinic in Kingston. FAMPLAN is trying to devise strategies to increase the sustainability of its male clinic. According to a FAMPLAN representative, "With the funding drying up, the clients are still coming."

6. Challenges

> "Its encouraging what we've achieved, but there is so much more to do."
> NGO

In addition to the constraints listed above, Jamaica faces several challenges to implementing reproductive health.

National Consensus and Policy on Reproductive Health

While considerable discussion at the national level has focused on the definition of reproductive health in Jamaica, a national consensus definition—and policy—has yet to emerge. One definition of reproductive health exists in draft form and is attached to a terms of reference for a change in the name and mandate of the Family Planning Coordinating Committee. The definition needs to be ratified—ultimately through a national reproductive health policy, but in the meantime at least by the NFPB, the MOH, and other organizations working on reproductive health activities. The definition needs to be disseminated to all levels of health care staff so that they will clearly know their roles in implementing a reproductive health approach that looks at clients as individuals rather than as family planning clients on Monday, STD clients on Tuesday, and so on. According to many respondents, until someone within the NFPB or MOH takes on the task of overseeing the process of drafting a reproductive health policy and coordinating organizations' implementation of reproductive health activities, Jamaica will make little progress toward implementing reproductive health activities. Similarly, until a decision is made regarding the name and functions of the Family Planning Coordinating Committee or until a reproductive health policy is drafted and enacted, Jamaica's definition of reproductive health will likely exist only on paper, failing to find practical application.

Operational Plans and Setting Priorities for Reproductive Health Elements and Services

Information about reproductive health problems is a prerequisite to setting priorities. Jamaica has been the subject of numerous studies on reproductive health needs and program issues; yet, as a donor representative noted, "The link between research and programs is not there." Jamaica lacks a resource center that could compile and retain study reports or other documentation. One donor respondent said that an inventory and review of research on reproductive health topics could inform priority setting.

Linked with defining reproductive health is the need to decide what services to integrate at what levels of the administration and service delivery system. As noted by a government official, integration must be well planned and systematically implemented. A government representative remarked, "Our biggest challenge is that we have a too-full agenda. Furthermore, reproductive health is taking place in an environment of competing demands." It is likely that family planning, MCH, and STD services will be integrated—at least to some extent—in the near future. But to help ensure efficient implementation of reproductive health, Jamaica needs to set clear priorities and plan what services will be available at service delivery points (Types I through IV) and with oversight by which department or departments in the MOH. Other challenges to integrating reproductive health identified by respondents include ensuring supplies of commodities and providing reproductive health materials for all levels of providers and clients.

Training for Providers

All respondents agreed with a government representative's assessment that "there needs to be a critical mass of trained providers to reach the community with reproductive health." It is not clear, however, who will design the curriculum for reproductive health training and who will fund the training. According to a government representative, "We need training for reproductive health, but donors don't want to fund more training." The large-scale training program for family planning funded by the World Bank concluded in 1994. Evaluations of the training revealed that the curricula were not well documented and that, in particular, training in counseling needed to be strengthened (PATH, 1992; McFarlane et al., 1996). As noted with FAMPLAN's experience in integrating STD and family planning services, training must be innovative and practical if it is to change provider attitudes and give providers the skills they need to interact with clients in accordance with a sexuality approach to reproductive health. The UWI/FMU also said that funding for its distance training programs is an issue. "Our challenge for training in reproductive health is funding to develop the programs we would like to develop."

New Role for the NFPB

As a statutory board, the NFPB is responsible for implementation of family planning policies and programs. Since the ICPD, the NFPB has been somewhat unsure of its function and therefore has been trying to define an expanded role for itself that would cast the board as the overseer of the implementation of reproductive health policies and programs. Others in Jamaica are also concerned about the continued role of the NFPB. Several respondents noted that the NFPB can fill gaps in activities related to reproductive health. Said a donor representative, "We need to orchestrate a discussion on the future of the NFPB. If they are going to continue, they need to look at training and to work with adolescents. They also need to be able to work with all sectors and NGOs." An NGO representative said, "The NFPB has a role to play—in advocacy, quality control for contraceptive products, and in education such as contraceptive technology updates." A government representative said, "The NFPB could play a key role in men's health. The MOH/PHC is not interested. They [the NFPB] could also do more for adolescent health because, again, the MOH isn't really interested. They could produce IEC materials. They could do monitoring and evaluation. They could do more training."

The statute authorizing the NFPB might need to be amended in order for the organization to expand its purview from family planning to reproductive health. Even with a new mandate, however, the organization will have to seek ways to become self-sustaining unless the government guarantees needed funding. As an NGO representative already noted, the NFPB could find itself competing with other reproductive health organizations for funding.

Designing Innovative Projects to Work with Adolescents

As noted by nearly all respondents, including donors, Jamaica's main focus in reproductive health is adolescents. A donor representative said, "That's a change since Cairo. It's legitimate to develop aggressive adolescent projects." Program planners, however, need to be innovative in reaching teens. If programs for youth are to succeed, youth themselves must be involved in designing them—including FLE. Programs for youth face several constraints, not the least of which is provider bias against serving adolescents. In addition, adolescents tend not to want to attend the same clinics as adults for fear of being seen by family, friends, or neighbors. According to an NGO representative, "Reaching adolescents through static clinics is not necessarily the best way. FAMPLAN has a clinic for adolescents, but they are frustrated that adolescents aren't coming. There is a perception among youth that adolescents who attend the clinic are dashing away their babies [getting abortions] or that the adolescents are sick." There is also a sense that programs need to start with adolescents when they are young. The longitudinal study being conducted by the FMU and FHI's Women's Studies Project has shown that gender norms and views on sex are formed by the time adolescents are age 12 or 13. Therefore, programs for adolescents need to begin earlier. An NGO representative concurred. "We need to start earlier with adolescents. Then it will take a decade to see the change. That is the only hope." A government representative said, "There are 1,000 youth groups islandwide. We need to work with them"

Another challenge to designing a reproductive health program for adolescents is the lack of staff in the NFPB and MOH to coordinate the work. According to a government representative, "On the adolescent program, we won't get off the ground without a person devoted full time to it for a year. It needs to be funded by UNFPA." In addition, the PIOJ is trying to obtain funding for an outreach project for youth. It wants to address reproductive health issues by building on an earlier islandwide forum it sponsored and engaging youth to generate solutions.

Reaching Men

Since Cairo, men's reproductive health has become a priority issue in Jamaica. According to a government representative, "We had a request in June 1997 from the planning unit for information for the prime minister to attend a Commonwealth Medical Association meeting on men's reproductive health since Cairo." How much attention men's reproductive health will receive in the coming years in Jamaica has yet to be determined. A government representative commented, "We need to decide the goals and objectives and then we can design programs for men."

Vision and Creativity

Jamaica is fortunate in commanding the political will and creativity to implement reproductive health as envisioned by the ICPD in Cairo. Given staff time and resources, the main challenge is to instill the vision of a client-centered, holistic, life-cycle approach to women's and men's reproductive health that is supported by quality information, counseling, and services available at all appropriate levels of the health care system. Designing innovative and participatory training programs for providers and programs for clients in accordance with a shared vision among stakeholders will help ensure that reproductive health moves from rhetoric to reality in Jamaica.

Appendix 1

Organizations Represented in the Interviews

Government Organizations	Ministry of Health (MOH), National Family Planning Board (NFPB), Planning Institute of Jamaica (PIOJ), Bureau of Women's Affairs
Nongovernmental Organizations	FAMPLAN, Women's Resource Outreach Centre (WROC)
Research	University of the West Indies, Fertility Management Unit (UWI/FMU)
Donors	U. S. Agency for International Development (USAID), United Nations Population Fund (UNFPA)
Private Sector	Medical Association of Jamaica (MAJ), Personal Choice/SOMARC
Service Providers	MOH nursing staff, private physicians

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